2010 Retiree Enrollment / Change Form

ARLINGTON

IMPORTANT: All participants must provide a social security number to enroll in coverage. Retirees and/or family members enrolled in a City plan AND eligible for Medicare (whether due to a disability, age, or other reason) must complete Section III below. Please provide a copy of your Medicare card to the City.

I. Personal Information – please print all information

Retiree Name _____ Gender _____ SSN _____
(Last Name, First Name)

If Surviving Spouse, Name _____ SSN _____

Address: _____ (_____) _____
Street Apt# Phone

City State Zip E-mail address

II. Retiree & dependent Information

Relationship and Plan	Last Name, First Name	Birthdate	Social Security No.*	Eff. Date
❍ RETIREE ❍ Medical ❍ Dental ❍ Vision				
❍ SPOUSE ❍ SURVIVING SPOUSE ❍ Medical ❍ Dental ❍ Vision				
❍ DAUGHTER ❍ SON ❍ Medical ❍ Dental ❍ Vision				
❍ DAUGHTER ❍ SON ❍ Medical ❍ Dental ❍ Vision				

*Social Security Number is REQUIRED for all participants effective January 1, 2010

III. Medicare Information

Last Name, First Name	Relationship	Eligible Date	Effective Date	Medicare Number	(Y= Yes N = No) Part A	Part B	Part D

IV. UnitedHealthcare Dental Place an "X" in the appropriate box below:

Plan	Retiree Only	Retiree and one dependent	Retiree and two or more deps.
DHMO	❍ $11.18	❍ $18.44	❍ $27.26
PPO Low	❍ $11.78	❍ $23.34	❍ $41.08
PPO High	❍ $28.41	❍ $56.27	❍ $99.04

❍ **I decline DENTAL coverage** for: ❍ myself / ❍ my spouse / ❍ my dependent children **DUE TO:** ❍ Existence of other coverage / ❍ Don't want/need

V. UnitedHealthcare Vision Place an "X" in the appropriate box below:

Plan	Retiree Only	Retiree and one dependent	Retiree and two or more deps.
Vision Plan	❍ $6.12	❍ $12.85	❍ $19.58

❍ **I decline VISION coverage** for: ❍ myself / ❍ my spouse / ❍ my dependent children **DUE TO:** ❍ Existence of other coverage / ❍ Don't want/need

For office use only:

Retiree # _____ Medical _____ R x 65 _____
Coverage Eff Date_____ Dental _____ Term File _____
Documentation _____ Vision _____ Lawson _____
Coupon Book_____ Med 65 _____ Finance _____

Retiree Medical / Pharmacy Plan Options

REMINDER: The City contribution toward retiree medical coverage is based on:
Date of retirement **prior to January 1, 2008**, OR • Date of retirement **after December 31, 2007**

What was your year of retirement?_____ Refer to the 2010 Monthly Retiree Rate chart that applies to your year of retirement to calculate the monthly cost of your benefit elections.

VI. Under Age 65 Plan Enrollment - UnitedHealthcare Medical & Pharmacy (Rx)

Plan	Coverage Level	Years of Service	Your Monthly Cost
❍ Value Medical & Rx	_____	_____	_____
❍ Core Medical & Rx	_____	_____	_____
❍ Plus Medical & Rx	_____	_____	_____

❍ **I decline MEDICAL and Rx coverage** for: ❍ myself / ❍ my spouse / ❍ my dependent children
DUE TO: ❍ Existence of other coverage / ❍ Don't want/need

VII. Age 65+ Plan Enrollment - Medicare Advantage or AARP Supplement Plan

Note: Both Secure Horizons and AARP require you complete their form and mail it to them to enroll. To change or drop coverage you are required to complete a City form AND personally notify AARP / Secure Horizons regarding your change in enrollment decisions. The City is not authorized to enroll, change, or drop coverage in these plans for you. You will be responsible for 100% of all billings for plans you enroll in if you do not notify both the City and Secure Horizons and/or AARP of your election change.

Plan	Coverage Level	Years of Service	Your Monthly Cost
❍ Secure Horizons with Rx	_____	_____	_____
❍ AARP K Supplement	_____	_____	_____
❍ AARP F Supplement	_____	_____	_____

❍ **I decline MEDICAL coverage** for: ❍ myself / ❍ my spouse
DUE TO: ❍ Existence of other coverage / ❍ Don't want/need

Coverage Level:
Retiree Only
Retiree + Spouse
Retiree + Child or Children
Retiree + Family

Years of Service:
retirement before 1.1.08:
10-14, 15-19, 20-24, 25-29, 30 & Over

Years of Service:
retirement after 12.31.07:
10, 11, 12, ...29, or 30 & Over

VIII. Age 65+ Pharmacy Plan Enrollment - UnitedHealthcare Medicare Part D Rx Plan

Plan	Coverage Level	Years of Service	Your Monthly Cost

Note: If at any time you are eligible for Medicare Part D and you decline this coverage, you are required to complete a UnitedHealth Rx Part D – Form to Decline Group Retiree Medicare Prescription Drug Plan Coverage form and return to Workforce Services, P.O. Box 90231 MS 63-0790, Arlington, TX 76004-3231 along with this Retiree Enrollment / Change Form.

❍ UHC Medicare Part D _____ _____ _____

❍ **I decline PART D PHARMACY coverage** for: ❍ myself / ❍ my spouse **DUE TO:** ❍ Existence of other coverage / ❍ Don't want/need

IX. Monthly Cost Payable to City of Arlington Insurance

$_____	+ $_____	+ $_____	+ $_____	+ $_____	= $_____
Dental	Vision	Under 65 Medical	Secure Horizons or AARP Plan	UHC Part D Rx	Total Payment

X. Mailing Address

Enrollment/Change Form:
City of Arlington
Benefits - MS 63-0790
PO Box 90231
Arlington, TX 76004-3231

Monthly Payments:
City of Arlington
Finance Dept. - MS 63-0820
PO Box 90231
Arlington, TX 76004-3231

XI. Retiree / Spouse Signature Required

_____ _____ _____ _____
Retiree Signature Date Spouse Signature Date

NOTE: Failure to complete decline statement may disqualify you for 31 day Special Enrollment Rights (please check all applicable items).